DWC-AD 10133.54
Request for Dispute Resolution Before the Administrative Director
For injuries occurring on or after 1/1/04

___Original ___Response

Has employer accepted this claim?
___ Yes ___ No
Has liability for injury been found by the WCAB?
___ Yes ___ No
Has more than 90 days of TTD been paid?
___ Yes ___ No

DWC Use Only

Social Security Number	**WCAB Number**	**DWC Unit Number**

Employee Name (Last) (First) (MI) Date of Birth

Address (Street) (City) (State) (Zip)

Employer Name	**Insurance Company Name; Or, if Self-Insured, Certificate Name**
Address	Adjusting Agency Name (if adjusted)
City, State, Zip	Claims Mailing Address
Date of Injury / **Claim Number**	City, State, Zip Phone No.
Employee Representative	**Employer Representative**
Firm Name	Firm Name
Address	Address
City, State, Zip Phone No.	City, State, Zip Phone No.

Qualified Rehabilitation Representative

Firm Name Representative Name

Address (Street, City, State, Zip Phone No.

The Administrative Director is requested to resolve the following dispute because the parties disagree on : (Please describe)

Summary of Parties' Informal Efforts to Resolve this Dispute	**Copies of this request with copies of medical reports and other pertinent documents have been served on:**
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Name of Requester **Date**	**Signature**

(Mandatory Form DWC-AD 10133.54 01/27/04)